

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155149</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>04/17/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HARCOURT TERRACE NURSING AND REHABILITATION</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>8181 HARCOURT RD</b> <b>INDIANAPOLIS, IN 46260</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00168651 and IN00169541 completed on March 16, 2015.</p> <p>This visit was in conjunction with the PSR to the PSR completed on March 16, 2015, for a Recertification and State Licensure Survey and the Investigation of Complaint IN00162422 completed on January 29, 2015.</p> <p>This visit was in conjunction with the PSR to the PSR completed on March 16, 2015, for the Investigation of Complaint IN00163279 completed on January 29, 2015.</p> <p>Complaint IN00168651-Corrected.</p> <p>Complaint IN00169541-Corrected.</p> <p>Survey dates: April 16 and 17, 2015.</p> <p>Facility Number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Census bed type: SNF: 9 SNF/NF: 91 Total: 100</p> <p>Census payor type: Medicare: 10 Medicaid: 71 Other: 19 Total: 100</p> <p>Sample: 5</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1  Harcourt Terrace Nursing and Rehabilitation was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00168651 and IN00169541.  Quality Review was completed by Tammy Alley RN on April 20, 2015.	{F 000}			